FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037515

Facility Name: MONTGOMERY PLACE

Address: 5550 S SHORE DRIVE (Number) CHICAGO (City) 60637 (Zip Code)

County: COOK

Telephone Number: (773) 753-4100 **Fax #** (773) 752-0056

IDPA ID Number: 363582046001

Date of Initial License for Current Owners: 1/24/1992

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (C) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) Marvin Fox, CPA

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,832	3,832	8
9	SNF/PED					9
10	ICF	6,834	19,990		26,824	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,834	19,990	3,832	30,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.31%

D. How many bed-hold days during this year were paid by Public Aid?
16 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/28/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,832

Medicare Intermediary Cahaba GBA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/02 Fiscal Year: 6/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	363,272	55,081	1,580	419,933		419,933	(25,650)	394,283			1
2	Food Purchase		521,275		521,275	(38,325)	482,950	(235,211)	247,739			2
3	Housekeeping	61,598	30,965	15,259	107,822		107,822	(33,559)	74,263			3
4	Laundry	50,092	10,260		60,352		60,352		60,352			4
5	Heat and Other Utilities			328,833	328,833		328,833	(238,739)	90,094			5
6	Maintenance	121,434	49,918	210,011	381,363		381,363	(128,301)	253,062			6
7	Other (specify):*											7
8	**TOTAL General Services**	596,396	667,499	555,683	1,819,578	(38,325)	1,781,253	(661,460)	1,119,793			8
	B. Health Care and Programs											
9	Medical Director			29,016	29,016		29,016		29,016			9
10	Nursing and Medical Records	1,403,739	104,090	594	1,508,423		1,508,423	(20,016)	1,488,407			10
10a	Therapy		1,447		1,447		1,447	(714)	733			10a
11	Activities	31,548	30,433	2,975	64,956		64,956		64,956			11
12	Social Services	50,735		5,022	55,757		55,757	(2,479)	53,278			12
13	Nurse Aide Training											13
14	Program Transportation	23,809	928		24,737		24,737	(12,996)	11,741			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,509,831	136,898	37,607	1,684,336		1,684,336	(36,205)	1,648,131			16
	C. General Administration											
17	Administrative	108,742			108,742		108,742		108,742			17
18	Directors Fees											18
19	Professional Services			307,715	307,715		307,715	(188,120)	119,595			19
20	Dues, Fees, Subscriptions & Promotions			128,427	128,427		128,427	(88,651)	39,776			20
21	Clerical & General Office Expenses	236,985	35,833	375,753	648,571		648,571	(319,636)	328,935			21
22	Employee Benefits & Payroll Taxes			765,660	765,660	38,325	803,985	(265,661)	538,324			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,198	10,198		10,198	(5,424)	4,774			24
25	Other Admin. Staff Transportation			9,475	9,475		9,475	(9,118)	357			25
26	Insurance-Prop.Liab.Malpractice			282,656	282,656		282,656	(205,214)	77,442			26
27	Other (specify):*											27
28	**TOTAL General Administration**	345,727	35,833	1,879,884	2,261,444	38,325	2,299,769	(1,081,824)	1,217,945			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,451,954	840,230	2,473,174	5,765,358		5,765,358	(1,779,489)	3,985,869			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MONTGOMERY PLACE #0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,001,014	1,001,014		1,001,014	(750,963)	250,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,500,000	1,500,000		1,500,000	(1,093,694)	406,306			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			54,436	54,436		54,436	(26,966)	27,470			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,555,450	2,555,450		2,555,450	(1,871,623)	683,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,269	503,928	680,197		680,197		680,197			39
40	Barber and Beauty Shops			272	272		272	(134)	138			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,917	50,917		50,917		50,917			42
43	Other (specify):*	153,033	196	1,020,140	1,173,369		1,173,369	(1,173,369)				43
44	**TOTAL Special Cost Centers**	153,033	176,465	1,575,257	1,904,755		1,904,755	(1,173,503)	731,252			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,604,987	1,016,695	6,603,881	10,225,563		10,225,563	(4,824,615)	5,400,948			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(58,251)	2		4
5	Telephone, TV & Radio in Resident Rooms	(288)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	76	30		9
10	Interest and Other Investment Income	(17,030)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,359)	21		24
25	Fund Raising, Advertising and Promotional	(1,573)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(15,562)	20		28
29	Other-Attach Schedule	(4,606,628)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,824,615)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,824,615)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OHF USE ONLY								
48		49		50		51		52

SEE ACCOUNTANTS' COMPILATION REPORT

MONTGOMERY PLACE

ID# 0037515
Report Period Beginning: 07/01/01
Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Services Revenue	$ (16,284)	21	1
2	Personal Care Services Revenue	(20,016)	10	2
3	Transportation Revenue	(12,538)	14	3
4	Church Home Administration Fee	(18,000)	21	4
5	Community Publication	(32,746)	20	5
6	Travel & Entertainment	(10,852)	21	6
7	Bank Charges	(526)	21	7
8	Entertainment	(5,730)	21	8
9	Public Relations Agency Fee	(46,767)	21	9
10	Community Outreach Program	(6,205)	21	10
11	Accrued Legal Fees	1,968	19	11
12	Non-Allowable Legal Fees	(67,515)	19	12
13	Vehicle Lease Late Fee	(191)	35	13
14	Non-Care Depreciation	(751,039)	30	14
15	Air Travel	(8,771)	25	15
16	Unsupported Seminar Expense	(771)	24	16
17	Capitalized Architect Fees	(6,000)	19	17
18	INDEPENDENT LIVING:			18
19	Dietary	(25,650)	1	19
20	Food	(176,960)	2	20
21	Housekeeping	(33,559)	3	21
22	Utilities	(238,739)	5	22
23	Maintenance	(128,301)	6	23
24	Therapy	(714)	10A	24
25	Social Service	(2,479)	12	25
26	Transportation	(458)	14	26
27	Professional Fees	(116,573)	19	27
28	Fees, Subscriptions	(38,770)	20	28
29	Office Expense	(89,625)	21	29
30	Employee Benefits	(265,661)	22	30
31	Seminar	(4,653)	24	31
32	Staff Transportation	(347)	25	32
33	Insurance	(205,214)	26	33
34	Interest	(1,076,664)	32	34
35	Equipment Rental	(26,778)	35	35
36	Barber & Beauty	(134)	40	36
37	Independent Living	(1,173,369)	43	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(4,606,628)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(25,650)											(25,650)	1
2	Food Purchase	(235,211)											(235,211)	2
3	Housekeeping	(33,559)											(33,559)	3
4	Laundry													4
5	Heat and Other Utilities	(238,739)											(238,739)	5
6	Maintenance	(128,301)											(128,301)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(661,460)											(661,460)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,016)											(20,016)	10
10a	Therapy	(714)											(714)	10a
11	Activities													11
12	Social Services	(2,479)											(2,479)	12
13	Nurse Aide Training													13
14	Program Transportation	(12,996)											(12,996)	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(36,205)											(36,205)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(188,120)											(188,120)	19
20	Fees, Subscriptions & Promotions	(88,651)											(88,651)	20
21	Clerical & General Office Expenses	(319,636)											(319,636)	21
22	Employee Benefits & Payroll Taxes	(265,661)											(265,661)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,424)											(5,424)	24
25	Other Admin. Staff Transportation	(9,118)											(9,118)	25
26	Insurance-Prop.Liab.Malpractice	(205,214)											(205,214)	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(1,081,824)											(1,081,824)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,779,489)											(1,779,489)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(750,963)											(750,963)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,093,694)											(1,093,694)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles	(26,966)											(26,966)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(1,871,623)											(1,871,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(134)											(134)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,173,369)											(1,173,369)	43
44	**TOTAL Special Cost Centers**	(1,173,503)											(1,173,503)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,824,615)											(4,824,615)	45

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Montgomery Place Independent Living Ctr.
Street Address: 5550 South Shore Drive
City / State / Zip Code: Chicago, IL 60637
Phone Number: (773) 753-4100
Fax Number: (773) 752-0056

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	168,047		$ 56,661	$	91,968	$ 31,011	1
2	2	Food	Meals	168,047		390,900		91,968	213,940	2
3	3	Housekeeping	Square Feet	234,706		46,224		64,305	12,665	3
4	5	Utilities	Square Feet	234,706		328,833		64,305	90,094	4
5	6	Maintenance	Revenue	9,446,873		259,929		4,784,008	131,628	5
6	9	Medical Director		1		29,016		1	29,016	6
7	10	Nursing / Medical Records		1		84,668		1	84,668	7
8	10A	Therapy	Revenue	9,446,873		1,447		4,784,008	733	8
9	11	Activities		1		33,408		1	33,408	9
10	12	Social Service	Revenue	9,446,873		5,022		4,784,008	2,543	10
11	14	Program Transportation	Revenue	9,446,873		928		4,784,008	470	11
12	19	Professioanl Fees	Revenue	9,446,873		236,168		4,784,008	119,595	12
13	20	Dues, Fees, Subscriptions	Revenue	9,446,873		78,546		4,784,008	39,776	13
14	21	Clerical & General Office	Revenue	9,446,873		205,128		4,784,008	91,950	14
15	22	Employee Benefits	Salaries	3,571,948		837,784		2,439,416	572,123	15
16	24	Travel & Seminar	Revenue	9,446,873		9,427		4,784,008	4,774	16
17	25	Staff Transportation	Revenue	9,446,873		704		4,784,008	357	17
18	26	Insurance	Square Feet	234,706		282,656		64,305	77,442	18
19	30	Depreciation	Actual			250,051			250,051	19
20	32	Interest	Square Feet	234,706		1,484,173		64,305	406,306	20
21	35	Equipment Rental	Revenue	9,446,873		54,245		4,784,008	27,470	21
22	39	Ancillary		1		680,197		1	680,197	22
23	40	Barber & Beauty	Revenue	9,446,873		272		4,784,008	138	23
24	42	Provider Participation Fee		1		50,917		1	50,917	24
25	TOTALS					$ 5,407,304	$		$ 2,951,272	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Montgomery Place Independent Living Ctr.
Street Address: 5550 South Shore Drive
City / State / Zip Code: Chicago, IL 60637
Phone Number: (773) 753-4100
Fax Number: (773) 752-0056

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	43	Independent Living		1		$ 1,173,369	$ 1,132,532		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,173,369	$ 1,132,532		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of Scotland		X	Mortgage		03/31/94	$ 25,605,000	$ 27,244,805			$ 1,500,000	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 25,605,000	$ 27,244,805			$ 1,500,000	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income										(17,030)	11
12	Alloc. To Independent Living										(1,076,664)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,093,694)	14
15	TOTALS (line 9+line14)						$ 25,605,000	$ 27,244,805			$ 406,306	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONTGOMERY PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONTGOMERY PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,305 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Montgomery Place Retirement Community: 170,401 SQ. FT, 165 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	13,650	1990	$ 653,213	1
2					2
3	TOTALS	13,650		$ 653,213	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1992	1992	$ 4,202,732	$ 140,091	30	$ 140,091	$	$ 1,472,135	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1993	27,363						9
10	Building Improvements			1994	18,462						10
11	Building Improvements			1995	23,710						11
12	Building Improvements			1996	4,958						12
13	Building Improvements: Carpet (Jan - June)			1997	4,058						13
14	Building Improvements: Outdoor Lighting (Jan - June)			1997	291						14
15	Building Improvements: Elevators			1998	51,767						15
16	Building Improvements: Electrical / Security			1998	8,989						16
17	Sprinkler System			Aug-98	1,525						17
18	Access Panels			Aug-98	1,825						18
19	Fire Dampers			Sep-98	3,884						19
20	10 Fire Dampers			Mar-99	2,036						20
21	Recovers for Window Awnings			Nov-98	1,526						21
22	Upper Cabinets			Apr-99	215						22
23	Renovations 2nd & 3rd Floor Walls			May-99	11,600						23
24	Start-up of Chiller Units			Jun-99	149						24
25	Sensors & Valves / Connectors			Jun-99	862						25
26	House Pump Bearing Assemble			Jun-99	1,032						26
27	Chilled Water Pump			Jun-99	307						27
28	A/C Compressor Repairs & Suction			Jun-99	2,696						28
29	Kitchen Hot Water System Repairs			Jun-99	557						29
30	2nd Draw on 2nd & 3rd Floor Renovations			Jun-99	11,600						30
31	Cleaned Dri-Steam Humidifiers			Jun-99	502						31
32	Paint Supplies			Jun-99	737						32
33	Repair to Canopy Structure			Jun-99	178						33
34	Inoperative Pison Assembly			Jun-99	980						34
35	Recovers for Window Awnings			Jun-99	1,526						35
36	Air Filters on Air Handler Units			Jun-99	55						36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Vac System & Air Damper	Jun-99	$ 1,069	$		$	$	$	37
38	Upper Cabinets	Jun-99	215						38
39	Steel Overhead Door	Aug-98	645						39
40	Elevator - Panaforty Detector	Jun-00	603						40
41	Kitchen Grease Exhaust	Dec-99	414						41
42	Nurse Call System	Nov-99	763						42
43	HVAC Coils	Jul-99	2,350						43
44	Pneumatic Controls	Jul-99	1,491						44
45	Roof Duct Insulation	Jul-99	2,916						45
46	Motor	Jul-99	544						46
47	A/C Valves	Jul-99	1,275						47
48	Risers	Nov-99	419						48
49	Fire Dampers	Nov-99	9,396						49
50	Drywall / Firestop	Feb-00	897						50
51	Replace Front Step	Sep-99	411						51
52	Shower Water Valves	Aug-99	437						52
53	Landscaping (not in 6/99 GL: not in 6/99 cost report)	Jun-99	1,062						53
54	Corridor Walls (not in 6/99 GL; not in 6/99 cost report)	Jun-99	3,178						54
55	Doors & Frames	Jul-99	2,625						55
56	Life Safety Code Review	Nov-99	679						56
57	Damper Drawings	Nov-99	683						57
58	Damper Drawings	Nov-99	730						58
59	Gutters & Drains	Dec-99	2,534						59
60	Light Covers	Mar-00	2,622						60
61	Faucet & Door Closer	Aug-99	190						61
62	Push Button Locks	Apr-00	683						62
63	Doors	Jun-00	178						63
64									64
65									65
66									66
67									67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 4,425,131	$ 140,091		$ 140,091	$	$ 1,472,135	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,425,131	$ 140,091		$ 140,091	$	$ 1,472,135	1
2	Doors & Frames	May-00	938						2
3	Air Handling Unit	Apr-00	4,630						3
4	Boiler Overhaul	May-00	1,184						4
5	Freezer Fan Motor	Apr-00	441						5
6	Kitchen Floor	Apr-00	9,551						6
7	Wallpaper & Paint	Jul-99	2,906						7
8	Paint	Dec-99	2,946						8
9	Window Treatments	Nov-99	453						9
10	Awnings	Apr-00	382						10
11	Garden Sprinkler Repair	May-00	1,151						11
12	Stainless Steel Wall Covering	Jun-00	3,961						12
13	Paving of Parking Lot	Sep-00	1,699						13
14	Sprinkler System Upgrage	May-01	629						14
15	Bookcases	Aug-00	959						15
16	Tile & Base	Sep-00	1,922						16
17	HVAC Rebuilding	Feb-01	31,519						17
18	Boiler Retubing	Feb-01	6,162						18
19	Boiler Connection to Annunciator	Feb-01	521						19
20	Floor / Ceiling	Mar-01	3,007						20
21	Boiler Retubing	Apr-01	664						21
22	HVAC Rebuilding	Apr-01	411						22
23	Flooring	Apr-01	1,130						23
24	Door & Hardware	May-01	270						24
25	Door Safety & Security	May-01	2,249						25
26	Flooring	May-01	3,074						26
27	Door Installation	May-01	281						27
28	Coutertops	Jun-01	107						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,508,278	$ 140,091		$ 140,091	$	$ 1,472,135	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,508,278	$ 140,091		$ 140,091	$	$ 1,472,135	1
2	Exhaust Fan	May-01	247						2
3	Light Fixture	May-01	144						3
4	Compressors	Feb-01	3,562						4
5	Compressors	May-01	8,138						5
6	HVAC Renovation	May-01	7,187						6
7	Telephone Lines	Mar-01	704						7
8	Window Treatments	Nov-00	15,198						8
9	Wallcovering	Apr-01	1,742						9
10	Window Treatments	Jan-01	1,107						10
11	Wallcovering	Apr-01	3,038						11
12	Carpeting	Apr-01	275						12
13	Carpeting	Feb-01	2,232						13
14	Carpeting	May-01	532						14
15	Interior Decorating	Sep-00	1,352						15
16	Architect Fees	May-02	1,921						16
17	Resurface Front steps	Aug-01	164						17
18	Resurface Front steps	Oct-01	329						18
19	Cast Iron Pipes	Oct-01	1,850						19
20	Cast Iron Pipes	Oct-01	1,644						20
21	Cleaned Ventilators	Oct-01	270						21
22	Carpeting	Jun-02	21,775						22
23	Elevator	Jun-02	932						23
24	Vinyl Plank	Sep-01	434						24
25	Ceiling Tiles	Sep-01	114						25
26	Ceiling Tiles	Oct-01	702						26
27	French Doors	Oct-01	308						27
28	Dining Room Renovation	Oct-01	9,668						28
29	Therapy Room Electrical	Oct-01	2,690						29
30	Recover Awning	Oct-01	1,589						30
31	Dining Room Cabinetry	Oct-01	874						31
32	Dining Room Renovation	Oct-01	7,036						32
33	Architect Fees	Jun-01	1,644						33
34	TOTAL (lines 1 thru 33)		$ 4,607,680	$ 140,091		$ 140,091	$	$ 1,472,135	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,607,680	$ 140,091		$ 140,091	$	$ 1,472,135	1
2	Dining Room Renovation	Oct-01	3,106						2
3	Dining Room Renovation	Oct-01	683						3
4	Fire Alarm	Oct-01	485						4
5	Architectural Services	Oct-01	4,012						5
6	Dining Room Renovation	Nov-01	1,664						6
7	Sprinkler Modification	Nov-01	268						7
8	Dining Room Renovation	Nov-01	3,266						8
9	Dining Room Renovation	Nov-01	145						9
10	Architectural Services	Nov-01	486						10
11	Dining Room Renovation	Dec-01	765						11
12	Dining Room Renovation	Dec-01	2,683						12
13	Solar Shades	Dec-01	135						13
14	Tempered Glass	Dec-01	110						14
15	Architectural Services	Jan-02	3,360						15
16	Carpeting	Jan-02	1,162						16
17	Replacement Glass	Jan-02	78						17
18	Dining Room Renovation	Jan-02	2,657						18
19	Painting	Jan-02	59						19
20	Architectural Services	Jan-02	787						20
21	Dining Room Renovation	Feb-02	1,500						21
22	Artwork	Apr-02	47						22
23	Hot Water System	Apr-01	1,640						23
24	Phone System	May-02	8,289						24
25	Phone System	Jun-02	12,295						25
26	Therapy Expansion	Jul-01	3,036						26
27	Therapy Expansion	May-01	1,524						27
28	Curtains	Jun-01	748						28
29	Therapy Window Shades	Oct-01	628						29
30	Curtains	Jan-02	359						30
31	Draperies	Nov-01	251						31
32	Smoke Detectors	Apr-02	1,918						32
33	TOTAL DEPRECIATION ON ALL IMPROVEMENTS			40,057		40,081	24	111,429	33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,665,826	$ 180,148		$ 180,172	$ 24	$ 1,583,564	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 523,579	$ 65,936	$ 65,936	$	10	$ 326,865	71
72	Current Year Purchases	26,788	2,927	2,979	52	10	2,979	72
73	Fully Depreciated Assets	8,807				10	8,807	73
74								74
75	TOTALS	$ 559,174	$ 68,863	$ 68,915	$ 52		$ 338,651	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1999 Ford Windstar Van	2000	$ 4,821	$ 964	$ 964	$		$ 2,410	76
77										77
78										78
79										79
80	TOTALS			$ 4,821	$ 964	$ 964	$		$ 2,410	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	5,883,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	249,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	250,051	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	76	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,924,625	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Allocation to Independent Living	$ 21,809,469	$ 853,247	$ 7,162,294	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 21,809,469	$ 853,247	$ 7,162,294	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 15,088 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transport	Ford F350 Terra Transit	$ 952.51	$ 12,383	17
18					18
19					19
20					20
21	TOTAL		$ 952.51	$ 12,383	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 231,914	$		$ 231,914	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			33,148			33,148	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			238,866			238,866	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				150,134		150,134	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						26,135		26,135	13
14	TOTAL			$		$ 503,928	$ 176,269		$ 680,197	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,064,829	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	869,497		3
4	Supply Inventory (priced at)	7,912		4
5	Short-Term Investments	278,439		5
6	Prepaid Insurance	14,171		6
7	Other Prepaid Expenses	2,800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,237,648	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	21,501,497		14
15	Leasehold Improvements, at Historical Cost	823,070		15
16	Equipment, at Historical Cost	2,109,862		16
17	Accumulated Depreciation (book methods)	(9,100,798)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,587,243	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,824,891	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,365,933	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,414		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,682		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,556		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	125,000		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	642,339		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,300,924	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	27,244,805		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 27,244,805	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 31,545,729	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (10,720,838)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 20,824,891	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (10,658,856)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (10,658,856)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,982)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (61,982)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (10,720,838)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,764,052	1
2	Discounts and Allowances for all Levels	(831,209)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,932,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	649,318	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 649,318	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	85,512	14
15	Telephone, Television and Radio	31,670	15
16	Rental of Facility Space	200,187	16
17	Sale of Drugs	151,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	157,943	21
22	Laundry	841	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 627,691	23
	D. Non-Operating Revenue		
24	Contributions	2,173	24
25	Interest and Other Investment Income***	17,029	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,202	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,934,527	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,934,527	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,163,581	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,819,578	31
32	Health Care	1,684,336	32
33	General Administration	2,261,444	33
	B. Capital Expense		
34	Ownership	2,555,450	34
	C. Ancillary Expense		
35	Special Cost Centers	1,853,838	35
36	Provider Participation Fee	50,917	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,225,563	40
41	**Income before Income Taxes (line 30 minus line 40)****	(61,982)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (61,982)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,532	6,054	$ 143,936	$ 23.78	1
2	Assistant Director of Nursing	1,120	1,184	34,876	29.46	2
3	Registered Nurses	8,394	9,333	185,147	19.84	3
4	Licensed Practical Nurses	13,174	14,015	254,757	18.18	4
5	Nurse Aides & Orderlies	80,970	89,022	749,675	8.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	832	872	14,153	16.23	9
10	Activity Assistants	2,587	2,822	17,395	6.16	10
11	Social Service Workers	2,470	2,661	50,735	19.07	11
12	Dietician	2,639	2,925	23,312	7.97	12
13	Food Service Supervisor	3,532	3,827	67,012	17.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,785	31,701	272,948	8.61	15
16	Dishwashers					16
17	Maintenance Workers	8,694	9,502	121,434	12.78	17
18	Housekeepers	7,776	8,531	61,598	7.22	18
19	Laundry	8,196	8,877	50,092	5.64	19
20	Administrator	510	567	23,888	42.13	20
21	Assistant Administrator					21
22	Other Administrative	1,065	1,175	84,854	72.22	22
23	Office Manager					23
24	Clerical	10,639	11,691	236,985	20.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,318	2,519	35,348	14.03	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	8,985	9,986	176,842	17.71	33
34	TOTAL (lines 1 - 33)	198,218	217,264	$ 2,604,987 *	$ 11.99	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	32	$ 1,580	01-03	35
36	Medical Director	monthly	29,016	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthy	100	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	2,975	11-03	44
45	Social Service Consultant	100	5,022	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	132	$ 38,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 494	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	$ 494		53

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Monica Ramirez	Administrator	0	$ 47,173
Michael Apa	Executive Director	0	83,830
Philip Johnson	CFO	0	83,733
Less allocation to Independent Living			(105,994)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 108,742

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Processing	$ 37,521
Frost Ruttenburg & Rothblatt	Accounting	64,788
Legatarchitects	Architects	7,148
Amy Salzman	Billing Service	43,053
Dorsky, Hodgeson, & Partners	Architects (capitalized-p. 5)	6,000
Personnel Planners	Unemployment Consult	200
Account Temps	Contracted Accounting	1,353
Various (see attached)	Legal	112,266
Various (see attached)	Computer Service / Support	35,386
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 307,715

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,401
Unemployment Compensation Insurance	
FICA Taxes	199,282
Employee Health Insurance	143,231
Employee Meals	38,325
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	635
Flex Benefits	173,341
Employee Appreciation / Relations	14,038
Drug Testing	3,753
Less allocation to Independent Living	(265,661)
FICA Taxes (Independent Living)	162,979
TOTAL (agree to Schedule V, line 22, col.8)	$ 538,324

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	60,104
Health Care Worker Background Check	2,448
(Indicate # of checks performed 204)	
Dues & Subscriptions	13,242
Licenses & Permits	2,751
Advertising	1,573
Community Publication	32,747
Yellow Page Advertising	15,562
Less allocation to Independent Living	(38,770)
Less: Public Relations Expense	(32,747)
Non-allowable advertising	(1,573)
Yellow page advertising	(15,562)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,775

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,427
Less allocation to Independent Living	(4,653)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,774

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MONTGOMERY PLACE # 0037515 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network $8326**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,268** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,917**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **38,325** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **58,251**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Frost, Ruttenbert & Rothblatt, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not complete at this time**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees